6-1-1981

An Introspection Of The Role Of The Nurse Practitioner

Cynthia H. Gaskins
Mississippi University for Women

AN INTROSPECTION OF THE ROLE OF THE NURSE PRACTITIONER

By

Cynthia H. Gaskins

A Thesis
Submitted to the Faculty of
Mississippi University for Women
in Partial Fulfillment of the Requirements
for the Degree of Masters of Science in Nursing
in the Department of Nursing
Mississippi University for Women

June 1981

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

AN INTROSPECTION OF THE ROLE

OF THE NURSE PRACTITIONER

By

Cynthia H. Gaskins

Phyllis W. Werner
Professor of Nursing
Director of Thesis

Nancy L. Herban
Assistant Professor of Nursing
Member of Committee

Mary Patricia Curtis
Assistant Professor of Nursing
Member of Committee

Harold M. Craft
Director of the Graduate School

Table of Contents

Abstract

The purpose of this research was to investigate whether nurse practitioners (NPs) desired to function collaboratively in a close relationship with a physician. The researcher also attempted to see if the tasks that NPs desired or believed themselves capable of performing were appropriate for the role as determined by a panel of authorities. A researcher-designed questionnaire was distributed to all licensed Mississippi NPs at the March meeting of NPs in Louisville, Mississippi, who volunteered to participate. Since some licensed Mississippi NPs were not present at this meeting, questionnaires were mailed to the remaining licensed NPs known to the researcher. The sample consisted of 45 respondents.

There were two hypotheses which the researcher subjected to testing and analysis. The first part of the questionnaire contained 26 questions regarding primarily demographic data and Hypothesis I. The second part of the questionnaire included 25 tasks in which the NPs indicated their present and desired manner of functioning. The researcher utilized descriptive statistics and tables to present the data collected.

Hypothesis I was concerned with whether NPs would indicate a desire to function collaboratively in a close relationship with a physician. Close relationship was defined as with protocols and physician back-up on the premises; or with protocols and physician back-up less than 25 miles away

with the physician visiting weekly, and the NP having means of direct communication with the physician. The researcher hypothesized that NPs would desire this type of relationship. Since 5 (11.1%) respondents desired to be 25 or more miles away, 10 (19.6%) desired physician visits less than once a week, 1 (2.2%) desired protocols to be nonexistent, and 1 (2.2%) desired independent practice; hypothesis I was rejected.

Hypothesis II stated that the tasks that NPs desire or believe themselves capable of performing are appropriate for the role as determined by a panel of authorities. Since some NPs desired or believed themselves capable of performing all or some of the seven tasks that the panel judged were not in the expanded role, hypothesis II was also rejected.

Acknowledgements

The writer wishes to extend sincere gratitude and thanks to Dr. Phyllis Werner, Professor, Mississippi University for Women, for her guidance in the development of this study.

The writer wishes to acknowledge her family for their love, understanding, and constant support; without which this study could not have been completed.

List of Tables

CHAPTER I

Origin and Statement of the Problem

The expanded role of the nurse was developed as a response to the problems of inequitably distributed medical manpower, increasingly expensive medical care, and the small numbers of physicians practicing primary medicine (Lawrence, DeFriese, Putnam, Pickard, Cyr, & Whiteside, 1977). Many selected functions of the physician have been effectively delegated to the nurse practitioner (NP). Studies have found that the quality of NP patient care, for those conditions appropriately delegated to them, is comparable to the care provided by physicians. Patient and physician acceptance has also been found generally favorable. The Congressional Budget Office's analysis reached the conclusion that NPs see about sixty percent as many patients per hour as physicians, but NPs' services could be provided by NPs at about two-thirds to four-fifths of the cost of physicians. It appears, then, that NPs can make a potentially great contribution to medical care services (Miike, 1979).

For the past fifteen years NPs have worked collaboratively with physicians to bring better health care to patients in rural areas where physician shortages existed. The recent predicted physician surplus has made physicians question the need of NPs. Many are especially concerned because the statutes of many states permit increasing areas of independent

practice by NPs. Some state delegates not only voice opposition to NPs but also support complete phasing out of this role ("Physician Extenders," 1980). A definite need exists for better communication and understanding between physicians and nurses if the NP movement is to survive in the 1980's.

Part of the present problem of collaboration and communication between NPs and physicians is the lack of uniformity in length, content, structure, and clinical practice of the NP educational programs. This has resulted in states having difficulties in establishing standards of practice for NPs. Most states have amended their NP acts to provide a general mandate for expanded role practice. It is the accompanying rules and regulations developed by the state boards of nursing alone or jointly with other health boards that actually define the scope of practice. These rules and regulations are nonexistant in some states, and in the majority of states they have not been definitively established because nurses, physicians, and other health board members have been unable to jointly reach an agreement. This has resulted in much role ambiguity for the NP. Much of the present conflict between physicians and nurses can be contributed to this unclear definition and role description (Bullough, 1975; Hall, 1975; Trandel & Korenchuk, 1978).

There remains a heated debate between nursing and medicine concerning how NPs will make diagnostic and treatment decisions in comparison to physicians (Mentink, Trolinger, & O'Hara-Davereaux, 1980). Many physicians believe that NPs are trying to perform functions that are overstepping

the boundaries of their role. Many researchers have studied the attitudes of physicians toward NPs and what physicians perceive to be their role (Banahan & Sharpe, 1979; Lawrence et al., 1977; Little, 1978). These studies support the fact that physicians' positions regarding NPs have always been varied. With the fears that were discussed previously, physicians are even more hesitant to support the NP role.

One factor affecting physicians' attitudes toward NPs is the predicted surplus of almost seventy thousand physicians by 1990 ("Prediction of F.P.," 1980). With this physician surplus a competition among physicians for the available patient population is inevitable. Also the number of physicians residing in rural areas should increase and thus will decrease dependency upon non-physician health care providers.

The 1980 Congress of the American Academy of Family Physicians (AAFP) strengthened its policy on NPs to make it clear that the AAFP recognizes a need for physician extenders but only when they are necessary because of physician shortages and only when they function under physician supervision. The Florida AFP proposed a resolution calling for reevaluation of the AAFP policy of all physician extenders including NPs. This resolution was proposed because of changes in the need for and utilization of physician extenders. Physicians believed that the quality of care would be compromised by the independent practice of the physician extenders. The Mississippi committee had the strongest opposition to this role. They suggested complete elimination of physician extenders by whatever means necessary ("Physician Extenders," 1980).

The problem is that physicians and nurses themselves do not fully agree on the exact tasks and the amount of supervision necessary for the NP. If agreement is achieved on the specific tasks appropriate for this role, then nurse-physician collaboration would increase the quality of health care. If this is not accomplished, then the continuation of the NP role is in jeopardy. Mentink et al. (1980) fear that closure and resolution of the NP movement could be based on political expediency rather than reasoned evaluation and a substantial data base. Even with a united stand by nursing, the NP movement's future is questionable.

The opinions discussed in the previous paragraphs are usually based upon what the physicians think NPs want to do. Very little concrete data has been collected on what the nurses see as their tasks and limitations. Physicians state that NPs want independent practice, yet NPs themselves state they want collaborative practice. This observation was made by the researcher during her educational program as a Family Nurse Clinician, and served to initiate the researcher's interest in delineating NP perceptions of their role. The researcher attempted to demonstrate that collaboration, not competition with the physician, is the goal of health care by the NP. Such evidence could serve to influence physician attitudes in a more favorable manner, thus promoting the increased quality of care resulting from nurse practitioner-physician collaboration (Blackwood, 1979; National Joint Practice Commission, 1977).

If no agreement is reached on the NP role, the future of the NP is in jeopardy. This possibility has great implications for health care. Studies

have shown that NPs raise physician productivity, lower health care costs, and help the maldistribution of health care. Another important function of the NP is health maintenance and preventive care (Fottler, 1979; Levine, 1977). If the NP's role is eliminated, all of these improvements in health care will cease to exist.

The purpose of this research was to delineate the role expectations of NPs. The researcher was seeking to answer the questions: What are the role expectations of NPs? To what extent do NPs want independent functioning and collaborative functioning?

CHAPTER II

Theoretical Framework

The theoretical basis for this study is role theory. Role theory represents a collection of concepts and a variety of hypothetical formulations that predict how occupants will perform in a given role, or what behaviors can be expected under what circumstances (Conway, 1978).

When a social structure creates very difficult, conflicting, or impossible expectations for its occupants, the condition is one of role stress. This role stress may generate role strain (subjective feelings of frustration, tension, or anxiety) in associated individuals. In health care organizations role strain may lead to a reduced quality of care and may even jeopardize lives. When role strain is present, dissatisfied, tension-ridden health care workers are often drained of both energy and commitment to the organization and to professional values (Hardy, 1978).

Problems due to role strain in the nurse practitioner can be seen in the following areas: role ambiguity, role conflict, and role incongruity. Role ambiguity may exist when participants in social systems do not entirely agree on which norms are relevant for a position. Some norms are vague, ill-defined, or unclear. Usually disagreements on role expectations are associated with a lack of clarity in role expectations rather than conflicting role expectations (Hardy, 1978).

Another condition that may produce role strain in the nurse practitioner (NP) is role conflict. This may exist when expectations are contradictory or mutually exclusive and thus impossible to carry out. Various role senders may hold conflicting expectations for the occupant of the role. Positions that link one system to another are especially subjected to high role stress. Studies of role conflict examine the existence of clear but competing role expectations (Hardy, 1978).

The NP also may experience role incongruity. This exists when a role occupant finds that expectations for his role performance run counter to his self-perception, disposition, attitudes and values (Hardy, 1978). Instances of this condition were studied with novices (Martin & Katz, 1961) and student nurses (Davis & Olesen, 1963) as both become exposed to the values of their profession.

Role ambiguity (Greene & Organ, 1973; Smith, 1957), role conflict (Greene & Organ, 1973), and role incongruity (Borgotta, 1961; Smelser, 1961) have all been found to be associated with relatively low levels of job performance. Studies have indirectly indicated that role performance is adversely affected by the presence of role strain. Studies (Bible & McComas, 1963; Getzels & Guba, 1954) clearly indicate that certain types of role stress can be detrimental to role enactment.

The effects of role strain in health care organizations can drastically curtail the quality of health care. The occupants of the role are not the only ones affected. Incongruity in role expectations can create conflict among related health care roles retarding their ability to function together.

Therefore the client receives a reduced quality of care from the role occupant and the whole health care system (Hinshaw, 1978).

The delivery of health care depends on the enactment or performance of a number of roles. Individuals occupying these roles hold expectations for their own performance and others have expectations concerning their performance. Intense conflict is created when these expectations are not met (Hinshaw, 1978). The researcher believes this role strain exists in the role of the NP. Expectations of the role of the NP that produce strain can greatly influence their productivity and job performance. If this assumed role strain does exist, then it is imperative that it be identified and eliminated so that better health care can result.

When considering role strain that may occur in work relationships, the degree of dependence upon the position is very important. This factor could significantly influence the decision to eliminate a role. Positions that have considerable commitment on the part of an actor are less easily eliminated than positions with relatively low commitment. Unless physicians are dependent on the NP role and see the value and need for this role in health care, the position is likely to be eliminated (Hardy, 1978).

CHAPTER III

Hypotheses

Theoretical Hypothesis I

When surveyed, nurse practitioners (NPs) will indicate a desire to function collaboratively in a close relationship with a physician.

Theoretical Hypothesis II

When the results of a questionnaire are analyzed, the tasks that nurse practitioners are presently performing and those tasks NPs desire to perform are appropriate for the expanded role.

Theoretical Definitions

1. Surveyed: given a written researcher-designed tool to answer.

2. Collaboratively: working together with mutually developed written protocols and physician assistance as needed.

3. Close relationship: with protocols and physician back-up on the premises; or with protocols and physician back-up less than 25 miles away with the physician visiting at least weekly, and the NP having means of direct communication with the physician. Degree of close relationship will be indicated by responses to questions 13, 15, 16, 18, 19, and 20 of Part I of the questionnaire.

4. Physician: a doctor of medicine who has agreed to work jointly with a NP.

5. Questionnaire: researcher-designed tool consisting of 25 tasks that NPs could consider within their role.

6. Analyzed: examined using descriptive statistics.

7. Tasks: any behavior related to administering patient care in primary care.

8. Nurse practitioner: any nurse licensed and functioning in the expanded role in Mississippi during the period of data collection.

9. Appropriate for the expanded role: as determined by a panel composed of a NP educator, representative of the board of nurses, and a physician in collaborative practice.

Operational Hypothesis I

When given a written researcher-designed tool to answer, NPs will indicate a desire to function by working together with mutually developed written protocols and physician assistance as needed, with protocols and physician back-up either on the premises or less than 25 miles away; and if the physician is not on the premises, it would be desirable to have physician visits at least weekly and to have means of direct communication with this doctor of medicine who has agreed to work jointly with the NP.

Operational Hypothesis II

When the results of a researcher-designed tool consisting of 25 tasks that NPs could consider within their role are examined using descriptive statistics, the behaviors related to administering patient care in primary care that nurses licensed and functioning in the expanded role in Mississippi during the period of data collection are performing or desire to

perform are appropriate for the expanded role as determined by a panel composed of a NP educator, representative of the board of nurses, and a physician in collaborative practice.

CHAPTER IV

Review of the Literature

The following review will first trace the development of the role of the nurse practitioner (NP). Then the various roles performed by the expanded nurse will be considered. Next several studies on physicians' attitudes toward NPs, clients' attitudes and acceptance of the NP, and NPs' perception of their role will be reviewed. Generally the studies assumed the NPs worked in collaboration with a physician, but the independent nurse role is also presented.

Development of the Expanded Role of the Nurse

The registered nurse role is rapidly changing as many nurses shed their traditional caution and take on an expanded role in primary health care. Several factors such as the shortage of primary care physicians, the growing consumer demand for adequate care, the increase in cost of health care, and improved technology in health care have contributed to the need for this role expansion (Bullough, 1976).

In the 1960's American medicine found itself in the midst of a primary care crisis. Doctors began to specialize which left fewer doctors in primary care practice. During this time when national attention was first focused on primary care, nursing was not interested in expanding its role. Nursing at this time was concentrating on developing higher education

within its profession, and saw such a role incompatible with the goal of professional autonomy and the philosophy of nursing. Nurses' disinterest in expanding their role in health care was a factor in the development of physician assistant programs with the first program at Duke University in 1965. Health professions trained ex-Vietnam medics as paramedics or physician assistants to meet this crisis (Mentink et al., 1980).

Nurses at this time faced several severe barriers. Traditionally, the physician-nurse relationship has been one of superordination-subordination. In the past many physicians simply did not think of nurses as being capable of independent or cooperative decision-making. Many nurses themselves experienced difficulty in accepting the role of decision making in the diagnosis and treatment process. They had been making diagnostic decisions for years but had protected themselves legally by casting the physician in the decision-making role (Bullough, 1976). Unlike the physicians' assistants, who are unlicensed nonprofessionals and free from any past stereotype, the registered nurse has experienced decades of professional subordination. Furthermore, nurses, who are usually female, have had to buck the social system as well since most physicians are male. These few reasons help justify nurses' slow move in filling the gap in the medical care system (Weisgerber, 1977).

However, the physician's assistant movement was an important factor in the development of NPs. It demonstrated that the delegation of specific tasks was possible. Then physicians began to see nurses as perhaps better-prepared assistants. It also gave courage to nurses to rethink their own

traditional avoidance of overt expansion of their functions onto the medical turf of diagnosis and treatment (Bullough, 1976).

The NP movement was encouraged by the American Academy of Pediatrics sponsoring conferences, research, and pronouncements supporting practitioners. In 1971 the Academy issued a joint statement with the American Nurses' Association suggesting guidelines for short-term courses for the preparation of practitioners (Bullough, 1976). Then came an explosion of short-term, continuing education programs. Some of these programs were devoid of academic standards and variable in graduate quality. All of these programs graduated what was termed "nurse practitioners". While the trend originally was for these practitioners to work in ambulatory care settings, it soon became obvious that they would function in a broad range of other care settings (Ford, 1979).

There are presently eighty-five certificate and one hundred fifty master's degree programs preparing NPs. The required program time varies from three to four months at the certificate level to twenty-one months at the master's level (Durbin & Zackerman, 1978). These programs prepare nurses in various areas: the family, adult, pediatric, school, community health, family planning, obstetric and gynecological, gerontological, mental health and college nurse practitioners. There are also practitioners in specialty areas such as neonatology and oncology (Treuting, 1979). NPs function in both solo and group practice settings in these varied areas of health care. Their responsibilities are as varied as the settings in which they work. They range from teaching and counseling of patients to numerous

clinical tasks (Levine, Ou, Sheatsley, Lohr, & Brodie, 1978).

NPs working in pediatrics provide well and sick child care, answer phone calls, and make newborn rounds and hospital visits (Karp, Metzler, & Hansen, 1973; Yankauer, Tripp, Andrews, & Connelly, 1972). NPs work in the area of counseling patients and parents (Aufhauser & Lesh, 1973) and conduct developmental testing (Schiff, Fraser, & Walters, 1969). They screen adult well patients, work with patients with chronic diseases and provide counseling (Hentiques, Virgadamo, & Kahane, 1974). Medical NPs are responsible for treatment of rashes, colds, minor trauma, and other acute self-limited illnesses (Coulehan & Sheedy, 1973). Weinstein and Dremers (1974) found that NPs are responsible for physical examinations, minor problems, prescriptions, laboratory tests, chronic problems, and minor accidents.

Physician Acceptance of the Expanded Role

One area that must be investigated when NP utilization is considered is physician acceptance of this role. Most of the literature concerning physician acceptance of NPs is of two types. The first type focuses on surveys of physicians undertaken to determine their attitudes toward this extended role. The second type is descriptive, based on specific cases of NPs and is generally developed from the experiences in one practice. The first type, surveys of physicians, is reviewed next (Levine, 1978).

Primary care physicians generally accepted the concept of the NP, but fewer were willing to employ them. According to O'Dell (1974), ninety-three percent of the selected physicians in two large medical centers

perceived an expanded role for nurses. Goye and Hansen's (1968) study of practicing physicians in Wisconsin found that sixty-one percent of the respondents thought that some form of mid-level practitioner was needed to improve the practice of medicine, and forty-two percent stated they would use such a person in their practice. In Wright's (1975) study fifty-five percent of the physicians favored the role, but only thirty-five percent were willing to employ a NP in the future. Fottler (1979) reinforces the fact that few physicians were willing to employ NPs with the fact that only twenty-nine percent of the 735 western New York physicians who responded to their questionnaires were willing to employ the nurse in this expanded role.

Little did a survey of primary care physicians in northern California and found several factors affecting physicians' willingness to employ NPs. A curvilinear relationship was found between the number of physicians in a group setting and their attitude toward employment of the NP. A setting with two or three physicians in joint practice appeared to be the optimum setting for employment of the NP. The most opposition came from physicians in practice by themselves followed by those physicians located in practice with four or more physicians. With more physicians competition increases for space, time, and money. Apparently the physicians become unwilling to divide the resources among more personnel (Little, 1978b).

From the above survey one may conclude that physicians who have been practicing medicine for shorter lengths of time, and who have had some prior experience with the expanded nurse are more apt to employ the

NP. Larger communities are less likely to employ NPs than rural communities. In addition, clientele affects the physician's attitudes. Practices with a higher proportion of female clients will employ a NP before practices with a more even sex distribution among patients (Little, 1978a).

An important determinant in physicians having favorable attitudes toward employment of the NP is prior experience working with nurses in the expanded role. By working with NPs physicians become acquainted with the role and become aware of the benefits a NP may bring to their practice. The physician can be more flexible in the use of his time for such things as illness, family time, and professional meetings. The volume of the physician's practice may increase as the clients accept the NP. As the physician experiences working with the nurse in the expanded role, he may find the role of supervising and teaching the NP stimulating (Little, 1978b).

A study was conducted to measure physician receptivity to NPs in North Carolina. The NP concept was approved by ninety-one percent of those responding. Of the physicians who approved of the concept, thirty-seven percent were willing to employ a practitioner. The study showed that previous direct experience working with NPs significantly increased both the willingness to delegate clinical tasks to these personnel and the desire to hire such a person in their practice. Of those responding, sixty-eight percent agreed to sharing their load with NPs in their offices, and six percent agreed to have them work in satellite clinics. Most of the physicians wanted their own nurse trained in a NP program that combined courses at a medical center with on-the-job training. The authors of this study concluded

that there was a demand for NPs in North Carolina (Lawrence et al., 1977).

Banahan and Sharpe (1979) conducted a study in Mississippi that further supported the findings of the New York and North Carolina studies. These researchers found that twenty-four percent of the physicians responding to the survey indicated they would like to employ a NP. Although thirty-four percent of the physicians did not care to employ a NP, they approved of the concept. Over half of the responding physicians approved of the concept of NPs. Most of the Mississippi physicians preferred a combination of formal and on-the-job training followed by the NP assuming duties within the office practice. Few of the physicians preferred the use of satellite NP clinics, but almost half of the respondents felt they were appropriate.

When considering salary, over half of the physicians believed annual salaries over fifteen thousand dollars were reasonable. About three-fourths of the physicians preferred a straight salary method of reimbursement as compared to only five percent favoring a fee for service basis. However, as acceptance and utilization of NPs increases, the acceptance of fee for service may also increase (Banahan & Sharpe, 1979).

Previous experience and knowledge of NPs were significantly associated with the acceptance of NPs. Of the physicians surveyed, fifty-three percent reported they had no previous experience with NPs, and sixty-seven percent did not personally know a physician who employs a nurse in the expanded role. When the physicians were asked if they knew enough about NPs to decide whether they approved of the concept, thirteen

percent of the responding physicians answered no. It appears that much of the physician opposition to NPs may be due to lack of knowledge about the role of the expanded nurse (Banahan & Sharpe, 1979).

One explanation for the reluctance of physicians to delegate clinical tasks to non-physician personnel can be associated with the process through which physicians are socialized to their own professional roles. This process includes legal, ethical, and scientific support systems which have developed to insure the consistent, high quality of professional practice within medicine. There are professional societies, meetings, hospital staffing arrangements, journals, and continuing medical education organizations in which academic medical centers figure as central strands for the development of new knowledge, procedures, and instrumentation (Lawrence et al., 1977).

This process of socialization implies continuous dialogue and learning which usually results in high levels of professional concensus in the diagnosis and treatment of disease. This process and consensus act to deter the delegation of clinically, ethically, and legally defined professional responsibilities to non-physicians who have not participated in this process. Some physicians are reluctant to reduce this "clinical concensus" to a set of procedural "protocols" by which the non-physician performs tasks conventionally part of the medical practice (Lawrence et al., 1977).

Another reason for the reluctance of physicians to accept the expanded role could be fear of a projected physician surplus. In the 1970's many

medical schools increased their enrollment because of the shortage of physicians in primary care. Now some scholars forecast an oversupply of physicians graduating from medical school. This fact could be one reason why some physicians' attitudes are conservative. If this surplus of physicians does exist in the next few years, it will definitely affect physicians' attitudes toward NPs (Beason, 1978).

The other type of literature concerning physician acceptance of NPs is descriptive and based on specific cases of NPs. MacKay, Alexander, and Kingsbury (1973) told of a pediatrician in a family health clinic who responded favorably to his employment of a NP. This pediatrician believed that the NP role should be well defined and centered on the utilization of specific technical skills.

In a similar report, three other pediatricians in joint practice who employed a NP were impressed with her clinical skills and her counseling abilities. These physicians thought the NP lightened their workload (Karp et al., 1973).

Schiff et al. (1969) found that a NP in one practice permitted a larger number of patients to be treated and increased the income of the practice. These physicians thought that the quality of patient care had improved since the NP joined the staff.

These three descriptive studies indicated positive attitudes toward NPs. However, it is hard to generalize these findings since they involve such small numbers of NPs and physicians.

Client Satisfaction of the Expanded Role

Another area that must be investigated if NPs are to be accepted health professionals is the question of client satisfaction with NPs. Andrews and Fenley (1975) stated that client acceptance of NPs had been so favorable that it is no longer an issue. However, the literature dealing with client acceptance of this extended role suggested that it is a concern (Levine, 1973).

Karp et al. (1973) did a study on client satisfaction of a NP employed in a private practice in New Jersey. The clients believed that the total quality of care was improved because the NP spent additional time counseling and teaching them.

Lewis and Resnik (1967) did a study on the utilization of nurses as the primary source of care for adult patients in the outpatient clinic at the Kansas Medical Center. Nurses' long-term management of ambulatory patients with chronic illnesses was compared to that of physicians. The study showed patients' acceptance of the nurse and a shift to her in their preferences as a provider of many services formerly received from a physician. The results also showed that the overall dollar cost for care was cheaper by the nurse than the physician.

Later another study was done on clients in an adult medical outpatient clinic. These clients had a negative reaction to the NP that gave them care. They were concerned with the title of the expanded role personnel. Many of the clients wished to see a physician rather than the NP. Clients expressed concern about the changes that were made in the established regimen

and about the continuity of care under this new system of medical care delivery (Kubala & Clever, 1974).

MacKay et al. (1973) reported on the attitudes of parents of children treated by a nurse who functioned as a physician associate in a pediatric practice. It was found that families who had experienced the NP's services were increasingly willing to accept her. Another study was done on parents of children treated by a NP. From questionnaires administered to parents at a pediatric clinic, DeCastro and Rolf (1973) found that the parents had positive attitudes toward the NP.

A rural population was surveyed to determine acceptance of NPs among a population that had not previously been exposed to such personnel. The adults were generally favorable toward the idea of the NP providing some routine medical care, but a physician was preferred in serious situations. Most of the respondents favored NPs working on a team with physicians (Chenoy, Spitzer, & Anderson, 1973).

Prescott and Driscoll (1980) reviewed twenty-six studies comparing physicians to NPs. These published and unpublished studies dated back to 1967. The researchers reported that the majority of the studies found no difference between NP and physician performance. The studies often overlooked the areas in which NPs actually scored higher than physicians. The following are some of the variables in which NPs received higher scores than physicians: amount and/or depth of discussion regarding child care, preventive health, and illness; amount of advice, therapeutic listening and support offered to patients; completeness of history including the recording

of previous problems and follow-up problems and therapies; completeness of physical examination and interviewing skills; and patients' knowledge about the management plan given to them by the provider.

The majority of the above investigations about physician and client satisfaction with NPs were developed from specific cases of employment of individual NPs in one practice. These studies generally involved small samples of physicians, NPs, and clients and were of short duration; however, this descriptive research identified many benefits associated with employing NPs.

Introspection of the Nurse Practitioner Role

When reviewing the literature on NPs' perception of the expanded role, Ward (1979) surveyed three hundred thirty-seven family nurse practitioners (FNPs) throughout the United States. The respondents judged themselves moderately competent to handle problems encountered, able to handle sixty-six percent of patient needs and problems without further referral or consultation. The study also investigated the sources in nursing education that were responsible for the major portion of the FNPs' current competencies.

Generally the literary review discusses NPs working in collaboration with and under the supervision of a physician. Kinlein (1977) describes another role of nursing in which the nurse practices independently. She believes the professional nurse should be and can be independent in any setting. Her nursing framework sees the nurse as an extension of the physician. The nurse must be known by the care she gives to the person, not

by the care she gives to the physician or any other health personnel. Thus, the client seeks nursing care in a setting not necessarily associated with medical practice. Although this is not the accepted role of the NP generally, this role concept does exist for some.

Analysis of the above studies and opinions about NPs shows that generally clients and physicians are satisfied with NPs. For continued successful utilization of this expanded role, nurses and physicians must negotiate so that misunderstanding between the professions can be resolved. Nurses need to define their role so that all professions will understand their role in delivering health care. Nurses and physicians need to identify what each profession, working in cooperation with others, can deliver and still maintain its own integrity. Physicians and nurses make different, but complementary, contributions to health care. Broad functions for each profession need to be identified, some shared and some individual or unique. Hopefully, investigating how NPs perceive their expanded role will help to close the gap that exists in the services (Gilchrist, 1978).

CHAPTER V

Research Design and Methodology

Research Approach

The type of research employed in this study was survey research. Polit and Hungler (1978) state that:

> survey research is that branch of research activity that focuses on the status quo of some situation and which normally collects this information directly from the group (or members of the group) that is the subject of investigation. (p. 195)

Survey research gathers data from a number of cases at a particular time. It is concerned with the generalized statistics that result when data are obtained from a number of individual cases. In this study the researcher's plan was to collect data on all licensed nurse practitioners (NPs) practicing in Mississippi.

Variables

The independent variables were the geographic area included in the study and the role of the NP. The intervening variables were the length of practice as a NP and as a nurse in general, the attitude of the NP responding to the questionnaire, the lack of the truthfulness on the part of the informant, age of the NP, sex of the NP, specific area that the NP practiced in, and the location of practice (rural clinic without physician on premises versus clinic with physician on premises). The dependent

variables were what tasks the NPs perceived to be in their role and the degree of collaborative functioning.

Setting, Population, and Sample

The setting for this study was the state of Mississippi. The population of Mississippi, according to the 1976 census, is 2,354,000. Mississippi is primarily a rural state in terms of population distribution with 75 percent of the population residing outside Standard Metropolitan Statistical Areas. Of the people in Mississippi 62.8 percent are white and 37.2 percent are nonwhite. The median family income is $6,071 per year, with $7,578 being the median for whites and $3,202 being the median for blacks. Mississippi ranks fiftieth among the nation's states in terms of median family income ("General Population," 1970).

Mississippi has only 82 physicians per 100,000 persons compared to the 1976 national average of 137 physicians per 100,000 (Bleich, 1979). The state has 25 federally-backed rural health clinics which had a budget of $11.5 million in 1979 and delivered services to about 80,000 people ("Misunderstanding Cuts Use," 1980). Settings in which primary care can be delivered by NPs in Mississippi include: individual offices, group practices, hospital outpatient departments, public health department clinics, special purpose clinics (e.g., family planning clinics, immunization clinics), mass screening programs (e.g., hypertension, cancer, glaucoma), and neighborhood health centers ("General Population," 1970).

The population for this study consisted of all licensed NPs practicing

in the state of Mississippi. The sample consisted of all those NPs responding to the questionnaire. A sample of at least 50 was desired for the study, but due to limitations of time and poor response the sample actually consisted of 45.

Data-Gathering Process

Data were collected from March through May of 1981. A researcher-designed questionnaire (Appendix A) was issued to all licensed Mississippi NPs at the March meeting of NPs in Louisville, Mississippi, who volunteered to participate. Since some NPs were not present at the March meeting, a mailed questionnaire accompanied by a letter stating the purpose of the study was sent to the remaining target population known to the researcher (Appendix B). No identifying information was required on the questionnaire to assure anonymity of respondents; however, each subject signed a consent form indicating willingness to participate in the study (Appendix C).

Procedure

The research-designed tool was of limited reliability and validity because of the lack of time and funding for complete pretesting; however, it is assumed to be reliable and valid within this study. It was pretested by 11 family nurse clinician graduate students at the Mississippi University for Women in Columbus, Mississippi.

The first part of the tool includes 26 multiple choice questions concerning demographic variables that describe NPs and their roles in primary

care. The tool looks at not only how the NP is currently functioning, but how she/he desires to function and the degree of collaboration with the physician existing and desired. The variables include: age, sex, area of NP preparation, type of basic nursing and NP preparation, length of nursing experience, site, population, and economic setting of NP practice, length of time in NP role, actual and desired distance from a physician, present and desired frequency of back-up physician visits and other forms of communication, degree of collaborative practice desired, type of present protocols and desired protocols, impressions of governing nursing laws, scope of practice, satisfaction with role and physician back-up, and preservation of role.

It is important to know not only what tasks the NP is performing and the degree of collaborative functioning in which she performs these tasks but also the tasks the NP desires to perform and the degree of collaborative functioning she desires. Then it can be determined if NPs are functioning the way in which they desire. The second part of the questionnaire includes 25 tasks in which the NPs describe their present and desired degree of collaborative functioning with a physician. The tasks may be performed without specific protocol, performed collaboratively with a close relationship with the physician, or not performed at all. Some of the tasks may be scored not applicable. The respondents also indicate if they think the tasks are beyond the scope of the expanded role.

Assumptions

1. NPs are an important member of the health care team and offer a valuable service to consumers.

2. NPs have expectations about their role.

3. Information about the expectations of NPs would enhance collaboration between NPs and physicians.

4. Information about the expectations of NPs will help clarify their roles and reduce role strain and ambiguity.

Limitations

1. The fact that the study was conducted in a Southern state may prevent generalization to other parts of the country.

2. The study of NPs can not be generalized to physician extenders.

3. The sample was drawn from volunteers.

4. The sample was of limited size.

CHAPTER VI

Analysis of Data

Forty-five questionnaires were partially or fully completed by nurse practitioners (NPs) and returned to the researcher. For unknown reasons 25 of the questionnaires contained at least one question unanswered. Of these 25, seven did not indicate the manner in which the practitioner desired to perform the tasks. One could assume that the practitioners were performing the tasks in the manner they desired, but this assumption was not made because the researcher believed that it would not be an accurate representation of the data. Several of the answers were contradictory, but the researcher used the responses as they appeared. Four NPs indicated preparation in two specialty areas. Of these four, one had preparation at the certificate level as a pediatric nurse practitioner (PNP) and at the master's level as a family nurse practitioner (FNP). Two of the remaining had preparation at the certificate level in both adult and pediatrics. The fourth was prepared as a FNP and PNP at the certificate level. At least eight of the NPs were practicing in more than one setting which also contributed to more than one answer in several of the questions. The raw demographic data by subjects regarding age, specialty, nursing preparation, NP preparation, years prior to and in the NP role, and site of practice are presented in Table 1.

TABLE 1

RAW DEMOGRAPHIC DATA

SUBJECT	AGE	SPECIALTY	NURSING PREPARATION	NP PREPARATION	PRIOR NURSING EXPERIENCE (YRS)	EXPERIENCE IN NP ROLE (YRS)	SITE OF PRACTICE
S1	29	PNP	DIP	CERT	3-5	1.5-3	HD
S2	25	PNP	DIP	CERT	1-3	.5-1.5	CHC
S3	49	FNP	AD	CERT	1-3	>3	CHC, PO, NC
S4	54	OB/GYN	DIP	CERT	≥10	>3	HD
S5	29	FNP	MS	MS	3-5	<.5	PO
S6	39	FNP	DIP	CERT	≥10	>3	PO
S7	32	OB/GYN	AD	CERT	≥10	1.5-3	CHC
S8	32	FNP	BS	CERT	5-10	.5-1.5	CHC
S9	40	AP	BS	CERT	5-10	>3	HOC
S10	31	FPNP	AD	CERT	3-5	>3	CHC
S11	28	FNP	AD	CERT	3-5	1.5-3	EAC
S12	37	PNP	DIP	CERT	≥10	1.5-3	CHC, C&Y
S13	43	PNP	AD	CERT	3-5	1.5-3	HD
S14	49	PNP	DIP	CERT	≥10	>3	HD
S15	37	PNP	AD	CERT	≥10	1.5-3	CHC
S16	41	NM	DIP	CERT	≥10	>3	HD
S17	33	FNP	MS	MS	3-5	>3	PO, NC, HD
S18	30	FNP	MS	MS	5-10	1.5-3	RHC
S19	46	NM	BS	CERT	≥10	>3	EP, HD
S20	32	AP	BS	CERT	<1	>3	HAO
S21	29	AP	BS	CERT	1-3	1.5-3	CHC
S22	29	AP/PNP	BS	CERT	1-3	>3	RHC
S23	47	FPNP	DIP	CERT	≥10	>3	CHC, HD
S24	29	FPNP	AD	CERT	1-3	<.5	HOC, HD
S25	31	FNP	DIP	CERT	3-5	1.5-3	RHC
S26	38	NM	DIP	CERT	3-5	.5-1.5	NC
S27	53	NM	AD	CERT	≥10	>3	CHC
S28	37	NM	DIP	CERT	5-10	>3	PO, HOC
S29	59	NM	DIP	CERT	≥10	>3	HD, EP
S30	33	FNP	MS	MS	5-10	1.5-3	RHC
S31	49	FNP	AD	CERT	<1	>3	NC
S32	20	OB/GYN	DIP	CERT	5-10	>3	CHC, HD
S33	55	OB/GYN	DIP	CERT	≥10	>3	HD
S34	34	PNP	AD	CERT	≥10	1.5-3	HOC
S35	35	AP	AD	CERT	≥10	1.5-3	HOC, RHC
S36	29	OB/GYN	BS	CERT	5-10	1.5-3	HD
S37	47	OB/GYN	DIP	CERT	≥10	>3	HD
S38	29	PNP	MS	MS	1-3	>3	HD, HOC
S39	47	FNP	AD	CERT	1-3	1.5-3	RHC
S40	50	NM	DIP	CERT	≥10	>3	HD
S41	26	FNP	BS	CERT	<1	1.5-3	CHC
S42	48	FNP	AD	CERT	3-5	.5-1.5	CHC
S43	46	PNP	DIP	CERT	≥10	.5-1.5	HD
S44	30	OB/GYN	BS	CERT	3-5	1.5-3	HD
S45	48	FPNP	DIP	CERT	≥10	>3	HOC

ABBREVIATIONS:

AP = ADULT PRACTITIONER
FNP = FAMILY NURSE PRACTITIONER
FPNP = FAMILY PLANNING NURSE PRACTITIONER
NM = NURSE MIDWIFE
OB/GYN = OBSTETRICS AND GYNECOLOGY
PNP = PEDIATRIC NURSE PRACTITIONER

AD = ASSOCIATE DEGREE
DIP = DIPLOMA
BS = BACCALAUREATE DEGREE
MS = MASTERS
CERT = CERTIFICATE

C&Y = CHILDREN AND YOUTH CLINIC
CHC = COMMUNITY HEALTH CENTER
EP = EDUCATIONAL PROGRAM
EAC = EMERGENCY AMBULATORY CARE
HD = HEALTH DEPARTMENT
HAO = HOSPITAL ADMISSION OFFICE
HOC = HOSPITAL OUTPATIENT CLINIC
NC = NURSE CLINIC
PO = PHYSICIAN'S OFFICE
RHC = RURAL HEALTH CLINIC

The age of the respondents ranged from 20-59 years. Eleven (24.4%) of the respondents were in the age group from 20 to 29 years, 16 (35.6%) were in the age group from 30 to 39 years, 13 (28.9%) were in the age group from 40 to 49 years, and 5 (11.1%) were in the age group from 50 to 59 years. The mean age of the respondents was 36.7. Of the 45 respondents, 2 were males and 43 were females. These data are represented in Table 2.

Table 2

Age and Sex Distribution

Age Range	Sex M	Sex F	Frequency (f)	Percent (%)
20-29	0	11	11	24.4
30-39	1	15	16	35.6
40-49	1	12	13	28.9
50-59	0	5	5	11.1

N = 45 = f
100 = %

Mean Age = 36.7 years
Range = 20-59
% of Males = 4.4
% of Females = 95.6

Sixteen of the respondents were FNPs with 13 of them presently performing as FNPs. Of the remaining three, two were functioning in the adult specialty area, and the other was practicing as a PNP for which she had received certificate preparation. Two of the 16 FNPs were also trained in pediatrics. Twelve respondents were trained as PNPs and 9 of the 12 were presently functioning in the area of pediatrics. Two of the remaining three PNPs also had preparation as APs and were functioning in the adult

area. The third PNP was prepared for and functioning as a FNP. All seven of the respondents who were prepared in the obstetrics/gynecology (OB/GYN) field were working in their specialty area. Seven practitioners were trained in nurse-midwifery (NM) and were functioning in this area. There was a total of three practitioners prepared in the adult specialty. Two of these three adult practitioners (APs) were also trained in pediatrics with one practicing adult and pediatrics and the other practicing in the adult area. The third was working as an AP with urology/oncology patients. There were four nurses trained as family planning nurse practitioners (FPNP), and all four functioned in this area. Table 3 shows the distribution of NPs by their area of specialty and compares the specialty areas of NP preparation to the specialty area of present NP practice. Since there was often more than one area of specialty preparation and practice, the total Ns for this table are N=49, and N=46.

Table 3

Specialty Preparation and Functioning

Specialty	Specialty Preparation	Specialty Area of Functioning
FNP	16	13
PNP	12	10*
OB/GYN	7	7
NM	7	7
AP	3	5**
FPNP	4	4
	N=49=Σf	N=46= Σf

* Includes one FNP

**Includes two FNPs, and two who were also PNPs

Since some of the respondents included two basic nursing preparations, the researcher used the highest nursing preparation when analyzing the question regarding the practitioner's basic nursing preparation. When considering the highest nursing preparation of the practitioners, 13 (29%) had associate degrees (AD), 18 (40%) were diploma (Dip.) graduates, 9 (20%) had baccalaureate (BS) degrees, and 5 (11%) were masters (MS) prepared. Thus 69% of the NPs held less than a baccalaureate (BS) degree. Table 4 demonstrates the highest degree held in the different areas of specialty preparation.

Table 4

Highest Nursing Preparation in Various Specialty Preparation

Specialty Preparation	AD (f)	AD (%)	Dip. (f)	Dip. (%)	BS (f)	BS (%)	MS (f)	MS (%)
FNP	6	13.3	2*	4.4	3	6.7	5	11.1
PNP	3	6.7	5	11.1	2**	4.4	0	0
OB/GYN	1	2.2	4	8.9	2	4.4	0	0
NM	1	2.2	5	11.1	1	2.2	0	0
AP	0	0	0	0	1	2.2	0	0
FPNP	2	4.4	2	4.4	0	0	0	0
Total	13	29	18	40	9	20	5	11

N = 45
*One has FNP also
**Also have APs

Of the 45 respondents, 40 (87%) had obtained practitioner preparation in certificate (Cert.) programs, 5 (11%) were MS prepared, and 1 (2%) person did not answer. All of the five MS prepared nurses were in the specialty area of FNP. Since 1 (2%) subject was both Cert. and MS prepared in two separate types of practitioner training, this resulted in a total of 46 for

analyzing these data.

There were the following number of practitioners working in the following sites: 13 (22.4%) in community health centers, 5 (8.6%) in physician's offices, 4 (6.9%) in nurse clinics, 18 (31.0%) in health departments, 7 (12.1%) in hospital outpatient clinics, 1 (1.7%) in an emergency ambulatory care, 1 (1.7%) in a children and youth clinic, 2 (3.4%) in education, 1 (1.7%) in a hospital admissions office, and 6 (10.3%) in rural health clinics. One masters prepared FNP worked in three sites: physician's office, nurse clinic, and the health department; one was employed in a physician's office; and, two worked in rural health clinics. The fifth MS prepared practitioner was employed by both a health department and a hospital outpatient clinic. Since many practitioners worked at more than one site, N=58 for analyzing these data. Table 5 shows the number of practitioners in each area of specialty preparation that practiced in a given site. In calculating percentages for these data, N=63 since subjects working in a site often had dual preparation and, two subjects were employed in three sites and nine were employed in two sites.

Eighteen (40%) of the respondents indicated that they had ten or more years experience prior to entering the NP role, while 3 (6.7%) had less than one year experience. Seven (15.6%) of the practitioners had between five and ten years experience, 10 (22.2%) had between three and five years experience, and 7 (15.6%) had between one and three years experience prior to the NP role.

Table 5

NP Preparation vs. Site of Practice

Site of Practice	FNP	PNP	OB/GYN	NM	AP	FPNP	(f)	(%)
Community Health Center	4	4	2	1	1	2	14	22.2
Physician's Office	4**	1		1			6	9.5
Nurse Clinic	3*			1			4	6.3
Health Department	2**	5	6	4		2	19	30.2
Hospital Outpatient Clinic	2*	2		1	1	2	8	12.7
Emergency Ambulatory Care	1						1	1.6
Children/Youth Clinic		1					1	1.6
Educational Program				2			2	3.2
Hospital Admission Office	1						1	1.6
Rural Health Clinic	5**	1				1	7	11.1
Total	22	14	8	10	2	7	63	100

*Each star represents one practitioner in this area with a MS

The duration of nursing experience obtained prior to the expanded role is shown for each specialty in Table 6. Since one NP was practicing in two areas, N=46 was used in analyzing these data.

Table 6

Years of Experience Prior to NP Role

Specialty	<1		1-3		3-5		5-10		≥10	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)
FNP	3	6.5	2	4.3	5	10.9	3	6.5	2	4.3
PNP			3	6.5	2	4.3	1	2.2	4	8.7
OB/GYN					1	2.2	1	2.2	5	10.9
NM					1	2.2	1	2.2	5	10.9
AP			2	4.3			1	2.2		
FPNP			1	2.2	1	2.2			2	4.3
Total	3	6.5	8	17.3	10	21.8	7	15.3	18	39.1
N = 46										

Of the 45 respondents 22 (48.9%) had worked more than three years as a NP; 16 (35.6%) had worked for one and one-half years to three years; 5 (11.1%) of the practitioners had worked six months to one and one-half years; and 2 (4.4%) had practiced in this role for less than six months. The years of nursing experience in the NP role is shown for each specialty in Table 7. When analyzing this data, N=46 was used because one practitioner was functioning in two specialty areas.

Table 7

Years of Experience in the NP Role

Specialty	< ½		½-1½		1½-3		> 3	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)
FNP	1	2.2	2	4.3	7	15.2	5	10.9
PNP			2	4.3	5	10.9	3	6.5
OB/GYN					3	6.5	4	8.7
NM			1	2.2			6	13.0
AP					1	2.2	2	4.3
FPNP	1	2.2					3	6.5
Total	2	4.4	5	10.8	16	34.8	23	49.9

N = 46

When considering the population setting of the NP practices, the following terms were defined: rural was 2,500 or less people; town was 2,501 to 5,000 people; small city (SC) consisted of 5,001 to 25,000 people; medium-sized (MSC) city was 25,001 to 100,000 people and large city (LC) had a population over 100,000. Sixteen (32%) of the respondents worked in rural areas and 12 (24%) worked in a large city. Nine (18%) of the nurses practiced in a town, 6 (12%) in a small city, and 7 (14%) in a medium-sized city. When analyzing this data, 50 was used as the total number of answers since three

respondents circled two answers and one respondent circled three answers. The population setting for each specialty area is shown in Table 8.

Table 8

Population Setting for Specialty Areas

Specialty Area	Rural		Town		SC		MSC		LC	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)
FNP	10	20	2	4	1	2	1	2	3	6
PNP	1	2	3	6	2	4	1	2	2	4
OB/GYN	0	0	2	4	3	6	2	4	0	0
NM	2	4	1	2	0	0	0	0	5	10
AP	2*	4	0	0	0	0	0	0	1	2
FPNP	1	2	1	2	0	0	3	6	1	2
Total	16	32	9	18	6	12	7	14	12	24

*Also functioning as PNP
N = 50

When considering patients' average income level, 27 (55.1%) practitioners worked in a low-middle (LMI) income setting and 19 (38.8%) practiced in a poverty (Pov.) income setting. Two (4.1%) practitioners worked in a middle (MI) income setting, 1 (2%) in an upper-middle income (UMI) setting, and zero in an affluent (Aff.) income setting. Forty-nine was used in analyzing this data since four of the 45 respondents chose two economic settings. The economic setting for each specialty area is shown in Table 9.

Twenty-two (42.3%) of the practitioners worked in the same office with their physician and 5 (9.6%) worked fifty or more miles from their physician. Ten (19.2%) of the nurses worked less than five miles away, 9 (17.3%) less than twenty-five miles away, and 6 (11.5%) less than fifty miles from their back-up physician (Table 10).

Table 9

Economic Setting for Specialty Areas

Specialty Area	Pov.		LMI		MI		UMI		AFF	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)
FNP	4	8.2	11	22.5	2	4.1	0	0	0	0
PNP	6	12.3	3	6.1	0	0	0	0	0	0
OB/GYN	0	0	7	14.3	0	0	0	0	0	0
NM	6	12.2	1	2.0	0	0	1	2.0	0	0
AP	2*	4.1	1	2.0	0	0	0	0	0	0
FPNP	1	2.0	4	8.2	0	0	0	0	0	0
Total	19	38.8	27	55.1	2	4.1	1	2.0	0	0

*Also functioning as PNP
N = 49

Table 10

Distance from Physician

Distance	Frequency (f)	Percent (%)
In same office	22	42.3
Less than five miles away	10	19.2
Less than 25 miles away	9	17.3
Less than 50 miles away	6	11.5
50 or more miles away	5	9.6
	N=52	100

This demonstrates that over half (61.5%) worked less than five miles from the back-up physician, and over three-fourths (78.8%) worked less than twenty-five miles from the back-up physician. Fifty-two was used as the total number of responses in analyzing this question because one practitioner had three responses and five NPs had two responses to this question.

When asked what methods of contact they had with their back-up physician, 26 (57.8%) practitioners had physicians that made visits to the clinic, 30 (66.7%) had telephone hook-up, and 12 (26.7%) of the respondents wrote in that they had direct contact with the on-site physician. For this analysis 45 was the number of possible responses for each part of this question.

The frequency of back-up physician visits to the nurses' practice site is shown in Table 11. Frequency of back-up physician visits ranged from 12 (23.6%) practitioners having visits several times a day to 3 (5.9%) practitioners having no physician visits at all. Four (7.8%) of the NPs had visits once a day, 6 (11.8%) had visits two to three times a week, 11 (21.6%) had visits once a week, 9 (17.7%) had visits two to three times a month, 2 (3.9%) had visits once a month, and 4 (7.8%) had visits less than once a month. The total number of responses to this question was 51 since six practitioners had two different distances from their back-up physicians.

Table 11

Frequency of Physician Visits

Visits	Frequency (f)	Percent (%)
None	3	5.9
Several times a day	12	23.5
Once a day	4	7.8
2-3 times a week	6	11.8
Once a week	11	21.6
2-3 times a month	9	17.7
Once a month	2	3.9
Less than once a month	4	7.8
	N = 51	100

Frequency of contact with back-up physicians by means other than visits ranged from 8 (17.8%) that had several contacts a day to 6 (13.3%) having no contacts (Table 12). Zero respondents had physician contact other than visits once a day, 8 (17.8%) had contact two to three times a week, 8 (17.8%) had contact once a week, 8 (17.8%) had contact two to three times a month, 3 (6.7%) had contact once a month, and zero practitioners had less than once a month contact other than visits with their physician. Four (8.9%) of the 45 respondents did not answer this question.

Table 12

Frequency of Contact by Non-Visit Means

Contact	Frequency (f)	Percent (%)
None	6	13.3
Several times a day	8	17.8
Once a day	0	0
2-3 times a week	8	17.8
Once a week	8	17.8
2-3 times a month	8	17.8
Once a month	3	6.7
Less than once a month	0	0
No answer	4	8.9
	N=45	100

Tables 13 and 14 present the data regarding frequency of physician visits to the site and frequency of contact other than visits. Since practitioners responded differently according to which site they were practicing in, N=56 and N=48 for these tables. One practitioner who was more than 50 miles from the back-up physician received no visits to the site and had

other contact only two to three times a month. However, another practitioner over 50 miles away had visits two to three times a week and other contact once a week. This illustration shows that distance did not necessarily effect the frequency of visits or contact.

Table 13

Correlation of Distance vs. Frequency of Physician Visits

Distance (miles)	None	Several/day	1/day	2-3/wk	1/wk	2-3/mo	1/mo	<1/mo
Same		12	4	4	3	1		
5	2	2			5	3		1
25					3	4		
50				1	2	1	1	1
50	1			1		1	1	2

N = 56

Table 14

Correlation of Distance vs. Frequency of Non-visit Physician Contact

Distance (miles)	None	Several/day	1/day	2-3/wk	1/wk	2-3/mo	1/mo	<1/mo
Same	6	6		2	3	1	1	
5	1	1		2	1	3	2	
25	1	1		4	1	1		
50	1			1	3		1	
50					2	3		

N = 48

Hypothesis I

Hypothesis I was concerned with whether NPs would indicate a desire to function collaboratively in a close relationship with a physician. Close

relationship was defined as with protocols and physician back-up on the premise; or with protocols and physician back-up less than 25 miles away, with the physician visiting weekly, and the NP having means of direct communication with the physician. The researcher hypothesized that NPs would desire such a relationship.

The distance that the NPs desired to be from their physician back-up is shown in Table 15. The answers ranged from 21 (46.7%) practitioners who desired to be in the same office with the physician to 5 (11.1%) practitioners who desired to be 25 to 50 miles away. Thirteen (28.9%) of the nurses desired to be less than five miles away, 6 (13.3%) nurses desired to be between 5 to 25 miles away, and zero respondents desired to be 50 or more miles away. These data indicate that 75.6 percent of the NPs would like to be within five miles of the collaborative physician.

Table 15

Desired Distance from Physician

Distance	Frequency (f)	Percent (%)
In same office	21	46.7
Less than 5 miles	13	28.9
Between 5 - 25 miles	6	13.3
Between 25 - 50 miles	5	11.1
50 or more miles	0	0
	N=45	100

Subjects were questioned regarding desired frequency of back-up physician visits to practice sites. The phrasing of the question was such

that subjects indicated the actual situation and any changes they would make. Since several respondents worked in several practice sites and were satisfied with the varying number of site visits, N=51 for this question. Responses ranged from 2 (3.9%) of the NPs who desired no visits to 15 (29.4%) who desired visits at least once a week. Of the total respondents, 96.1% wanted visits once a month or more often. The breakdown of frequency of desired visits can be found in Table 16. Of the two subjects who did not desire visits, one worked two clinics which were in the same office or less than five miles from the back-up physician. She/he also desired contact by other means several times a day in the clinic that was not on the premises. The other subject answering no was employed by the state health department and did not desire physician visits at two of the practice sites but did at the other three practice sites.

Table 16

Desired Frequency of Physician Visits

Visits	Frequency (f)	Percent (%)
None	2	3.9
Several times a day	12	23.5
Once a day	5	9.8
2-3 times a week	7	13.7
Once a week	15	29.4
2-3 times a month	6	11.8
Once a month	4	7.8
Less than once a month	0	0
	N=51	100

The third question relating to this hypothesis concerned desired contact with back-up physician by means other than visits. Responses ranged from 6 (13.3%) who desired no contact other than visits to 26 (57.8%) who desired other contact at least once a week. Four subjects (8.9%) did not respond to the question. Table 17 shows the desired frequencies of contact other than visits. Of the six who desired no contact other than visits, five desired visits several times a day and one desired visits two times a week.

Table 17

Desired Frequency of Contact by Non-Visit Means

Contact	Frequency (f)	Percent (%)
None	6	13.3
Several times a day	7	15.6
Once a day	1	2.2
2-3 times a week	9	20.0
Once a week	9	20.0
2-3 times a month	7	15.6
Once a month	2	4.4
Less than once a month	0	0
No answer	4	8.9
	N=45	100

When asked about their desire for collaborative practice, one NP (2.2%) stated the desire for independent practice. Four nurses (8.9%) did not answer the question. The remaining 40 (88.9%) respondents desired collaborative practice. The one practitioner who desired independent practice was 49 years old, a registered nurse with an associate degree who had

been prepared as a NP in a certificate program. The subject worked in a nurse clinic with physician back-up less than 25 miles away. Experience prior to the NP role consisted of less than one year, and experience in the NP role consisted of over three years. It was possible that this subject did not understand the question since in Part II, the NP indicated a desire to perform all but four tasks collaboratively.

How detailed the NPs believed protocols should be and how detailed their present protocols actually were is shown in Table 18. None of the practitioners believed that protocols should be very restrictive, and 36 (80%) of the respondents said they should be detailed but allowing for nursing judgment. Seven (15.6%) believed protocols should be very general, 1 (2.2%) believed they should be nonexistent, and 1 (2.2%) omitted the question. The one respondent that believed protocols should be non-existent was an associate degree registered nurse with certificate NP preparation. This 49 year-old respondent had worked more than three years in the expanded role and presently worked in the same office with the back-up physician. This NP was one of the two respondents who said they were unhappy with the NP role.

Thirty seven (82.2%) of the practitioners were satisfied with their present protocols. Five (2.2%) believed their protocols were too restrictive, 1 (2.2%) believed they were too general, and 1 (2.2%) respondent omitted this question. The one practitioner who was working with nonexistent protocols believed that protocols should be detailed but allowing for nursing

Table 18

Detail of Protocols

Protocols	Frequency (f)	Percent (%)
Should be:		
Very restrictive	0	0
Detailed but allowing for nursing judgment	36	80.0
Very general	7	15.6
Nonexistent	1	2.2
No answer	1	2.2
Are:		
Adequate	37	82.2
Too restrictive	5	11.1
Too general	1	2.2
Nonexistent	1	2.2
No answer	1	2.2
	N=45	100

judgment. Four of the respondents who thought their protocols were too restrictive agreed also that protocols should be detailed but allowing for nursing judgment. The other respondent who thought his/her protocols were too restrictive was the only practitioner who believed that protocols should be nonexistent.

When surveyed, all of the NPs did not indicate a desire to function collaboratively in a close relationship with a physician as defined by the researcher. For this reason, hypothesis I was rejected.

Hypothesis II

Hypothesis II concerns whether the tasks that NPs desire or believe themselves capable of performing are appropriate for the role as determined

by a panel of authorities. The researcher asked the respondents three questions concerning the scope of practice of the expanded role. Then the respondents were given 25 tasks and asked which they believed were in the expanded role.

The practitioners were to indicate how they were presently performing the tasks as well as how they desired to perform the tasks. The responses that the NPs gave to the three questions are shown in Table 19. First, they were asked if they were performing tasks that they believed were or should have been beyond the scope of the NP role. They were to explain if their answer was yes. Four (8.9%) of the practitioners said yes, 39 (86.7%) answered no, and 2 (4.4%) did not answer. Two of the practitioners who answered yes said they were handling medical problems beyond the scope of an OB/GYN practitioner. Another practitioner said there were expectations to make medical assessments beyond the scope of the practitioner. The other practitioner was pressured to see triaged patients rather than just assigned patients due to shortage of personnel.

Next, the nurses were asked if they believed that all of the functions that were expected of them and the tasks that they performed were covered by the rules and regulations of their particular specialty. Thirty-five (77.8%) of the practitioners answered yes, 9 (20%) of them answered no, and 1 (2.2%) person omitted the question.

The third quesion asked if they believed the existing rules and regulations governing their specific practice were specific enough. Thirty-one

Table 19

Rules and Regulations of the Expanded Role

Question		Frequency (f)	Percent (%)
Are you performing tasks that you believe are or should be beyond the scope of your nurse practitioner role?	Yes	4	8.9
	No	39	86.7
	No Answer	2	4.4
Do you believe that all of the functions that are expected of you and the tasks that you perform are covered by the rules and regulations of your particular specialty?	Yes	35	77.8
	No	9	20.0
	No Answer	1	2.2
Do you believe that the existing rules and regulations governing your specific practice are specific enough?	Yes	31	68.9
	No	12	26.7
	No Answer	2	4.4
		N=45	100

(68.9%) thought that they were and 12 (26.7%) believed that they were not specific enough. Two (4.4%) respondents did not answer.

Part II of the questionnaire inquired about how the NPs were presently performing and how they desired to perform 25 tasks. The data in this section were difficult to analyze as the subjects often omitted responding to certain tasks. Also, almost half the respondents did not complete the desire to perform section on many of the tasks. The responses to the tasks that were considered showed a large variance in how NPs were performing. Fourteen (31.1%) responded that collaboration was needed to take a routine medical history, 19 (26.7%) that collaboration was needed for health teaching. On the other hand, 2 (4.4%) NPs were beginning initial medication

treatment for hypertension without specific protocol, 4 (8.9%) were adjusting hypertension medication without specific protocol, and 6 (13.3%) were prescribing diabetic diets without specific protocol. The actual breakdown of performance is presented in Table 20.

As to the manner in which NPs desired to perform, 5 (11.1%) desired collaboration in taking a routine medical history, 8 (17.8%) wanted collaboration in palpating the uterus for fetal position, and 11 (24.4%) desired collaboration for health education. Some NPs desired to perform tasks without specific protocol that the panel believed should be conducted with collaboration, ie., beginning treatment for hypertension, ordering new diabetic diets, managing patients with chronic disorders, and/or adjusting medication for hypertension. These data are presented in Table 20.

The panel's decision regarding the tasks is also indicated in Table 20. When considering which tasks were not in the expanded role, less than half of the respondents chose the same tasks as the panel. Since the subjects' responses were not consistent with the panel's decision, the researcher rejected hypothesis II.

Additional Findings

The researcher had some additional findings about the continuation of the expanded role that did not directly relate to either hypothesis, but which the researcher believes are of interest. Thirty-one (68.9%) of the NPs believed they had adequate back-up from their physician, 12 (26.7%) did not believe they had adequate physician back-up, and 2 (4.4%) omitted

TABLE 20

MANNER OF NURSE PRACTITIONERS' ACTUAL AND DESIRED PERFORMANCES

TASK	PANEL DECISION	N/A		NOT IN ROLE		ACTUAL PERFORMANCE: WSP		ACTUAL PERFORMANCE: COLLAB		ACTUAL PERFORMANCE: NOT PERFORMING		DESIRE TO PERFORM: WSP		DESIRE TO PERFORM: COLLAB		NOT TO PERFORM	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
TAKE A ROUTINE MEDICAL HISTORY	WSP	0	0	0	0	29	64.4	14	31.1	0	0	24	53.5	5	11.1	0	0
REMOVE SUTURES	WSP	14	31.1	8	17.8	16	35.6	7	15.6	4	8.9	13	28.9	9	20.0	5	11.1
COUNSEL PATIENTS ON FAMILY PLANNING	COLLAB	1	2.2	0	0	25	55.6	19	42.2	1	2.2	18	40.0	11	24.4	1	2.2
PRESCRIBE DIABETIC DIETS FOR NEW DIABETICS	COLLAB	15	33.3	8	17.8	6	13.3	12	26.7	9	20.0	7	15.6	13	28.9	6	13.3
MANAGE PATIENTS WITH CHRONIC DISORDERS	COLLAB	14	31.1	6	13.3	3	6.7	23	51.1	3	6.7	5	11.1	19	42.2	3	6.7
PROVIDE ROUTINE PRENATAL CARE	COLLAB	14	31.1	5	11.1	8	17.8	16	35.6	9	20.0	4	8.9	17	37.8	5	11.1
ASPIRATE JOINT FLUID FROM KNEES	NOT IN ROLE	20	44.4	23	51.1	0	0	1	2.2	13	28.9	0	0	1	2.2	20	44.4
PERFORM COMPLETE PHYSICAL EXAM	WSP	0	0	0	0	18	40.0	25	55.6	1	2.2	18	40.0	16	35.6	0	0
TAPE ANKLE, WRIST OR KNEE FOR IMMOBILIZATION	COLLAB	18	40.0	7	15.6	10	22.2	6	13.3	11	24.4	6	13.3	12	26.7	10	22.2
PALPATE UTERUS FOR FETAL POSITION	WSP	13	28.9	5	11.1	15	33.3	12	26.7	6	13.3	10	22.2	8	17.8	5	11.1
REGULATE MEDICATION DOSAGE FOR DIABETICS	COLLAB	21	46.7	11	24.4	1	2.2	13	28.9	8	17.8	1	2.2	17	37.8	7	15.6
ADJUST MEDICATION FOR PATIENT WITH BENIGN ESSENTIAL HYPERTENSION	COLLAB	21	46.7	11	24.4	4	8.9	14	31.1	5	11.1	3	6.7	14	31.1	5	11.1
PERFORM WELL-BABY CHECK-UPS	WSP	12	26.7	5	11.1	14	31.1	18	40.0	3	6.7	9	20.0	15	33.3	5	11.1
INTERPRET EKG	NOT IN ROLE	21	46.7	15	33.3	2	4.4	10	22.2	8	17.8	3	6.7	12	26.7	11	24.4
DIAGNOSE AND TREAT ACUTE OTITIS MEDIA	COLLAB	14	31.1	7	15.6	6	13.3	21	46.7	4	8.9	5	11.1	18	40.0	5	11.1
INCISE AND DRAIN ABSCESS	NOT IN ROLE	17	37.8	14	31.1	4	8.9	9	20.0	11	24.4	0	0	18	40.0	11	24.4
PROVIDE HEALTH EDUCATION	WSP	0	0	0	0	27	60.0	9	20.0	0	0	21	46.7	11	24.4	1	2.2
BEGIN INITIAL MEDICATION TREATMENT FOR HYPERTENSIVE	COLLAB	21	46.7	12	26.6	2	4.4	14	31.1	6	13.3	2	4.4	14	31.1	7	15.6
DILATE PUPILS	NOT IN ROLE	27	60.0	16	35.6	2	4.4	2	4.4	11	24.4	0	0	6	13.3	18	40.0
MONITOR HEALTH STATUS OF CHRONICALLY ILL OR POST-OPERATIVE PATIENTS THROUGH HOME AND HOSPITAL VISITS	WSP	21	46.7	8	17.8	8	17.8	6	13.3	10	22.2	5	11.1	13	28.9	6	13.3
SUTURE USING LOCAL ANESTHETIC	COLLAB	19	42.2	10	22.2	6	13.3	11	24.4	10	22.2	2	4.4	18	40.0	9	20.0
PRESCRIBE NON-CONTROLLED MEDICATION	COLLAB	3	6.6	1	2.2	6	13.3	32	71.1	1	2.2	5	11.1	29	64.4	0	0
SET FRACTURES	NOT IN ROLE	23	51.1	21	46.7	0	0	2	4.4	13	28.9	0	0	2	4.4	19	42.2
MANAGE PSYCHOTIC PATIENTS	NOT IN ROLE	20	44.4	18	40.0	1	2.2	6	13.3	11	24.4	0	0	6	13.3	16	35.6
ORDER STEROIDS FOR DISEASES OF THE EYE	NOT IN ROLE	21	46.7	20	44.4	0	0	4	8.9	12	26.7	0	0	5	11.1	18	40.0

ABBREVIATIONS:
N/A = NOT APPLICABLE
NOT IN ROLE = BEYOND THE SCOPE OF THE EXPANDED ROLE
WSP = WITHOUT SPECIFIC PROTOCOL - PERFORMED WITHOUT SPECIFIC PROTOCOL/CONSULTATION
COLLAB = COLLABORATIVELY - PERFORMED EITHER BY DEFINITIVE PROTOCOL, TELEPHONE/PERSONAL CONSULTATION

N = 45

the question. When asked which they would contribute to the effort for preservation of the NP role, 12 (26.7%) answered money, 36 (80%) answered time, and 4 (8.9%) answered neither. Forty-two (93.3%) said they anticipated continuation of the NP role. One (2.2%) person did not anticipate the expanded role to continue and 2 (4.4%) wrote in that they were unsure. Forty-three (95.6%) of the practitioners were satisfied with their role and 2 (4.4%) were not satisfied with their NP role.

CHAPTER VII

Summary, Conclusions, Implications, and Recommendations

Summary

The purpose of this research was to investigate whether nurse practitioners (NPs) desired to function collaboratively in a close relationship with a physician. The researcher also attempted to see if the tasks that NPs desired or believed themselves capable of performing were appropriate for the role as determined by a panel of authorities. A researcher-designed questionnaire was distributed to all licensed Mississippi NPs at the March meeting of NPs in Louisville, Mississippi, who volunteered to participate. Since some licensed Mississippi NPs were not present at this meeting, questionnaires were mailed to the remaining licensed NPs known to the researcher. The sample consisted of 45 respondents.

There were two hypotheses which the researcher subjected to testing and analysis. The first part of the questionnaire contained 26 questions regarding primarily demographic data and Hypothesis I. The second part of the questionnaire included 25 tasks in which the NPs indicated their present and desired manner of functioning. The researcher utilized descriptive statistics and tables to present the data collected.

Hypothesis I was concerned with whether NPs would indicate a desire to function collaboratively in a close relationship with a physician. Close

relationship was defined as with protocols and physician back-up on the premises; or with protocols and physician back-up less than 25 miles away with the physician visiting weekly, and the NP having means of direct communication with the physician. The researcher hypothesized that NPs would desire this type of relationship. Since 5 (11.1%) respondents desired to be 25 or more miles away, 10 (19.6%) desired physician visits less than once a week, 1 (2.2%) desired protocols to be nonexistent, and 1 (2.2%) desired independent practice; hypothesis I was rejected.

Hypothesis II stated that the tasks that NPs desire or believe themselves capable of performing are appropriate for the role as determined by a panel of authorities. Since some NPs desired or believed themselves capable of performing all or some of the seven tasks that the panel judged were not in the expanded role, hypothesis II was also rejected.

Conclusions and Implications

The researcher concluded from these findings that the manner in which NPs are functioning varies greatly. Although most of the NPs surveyed were practicing in close collaboration with a physician as defined by the researcher, there remained some NPs without adequate back-up supervision. This not only is dangerous and confusing for the NPs, but it could have a serious effect on health care.

The data from this study indicated that 69% of the NPs had less than a baccalaureate degree in nursing. Of the 45 respondents, 40 (87.0%) had obtained their NP preparation in certificate programs. The researcher

questions the clinical knowledge base that NPs with limited educational preparation possess. This research also found that 22.3 percent of the NPs had less than three years nursing experience prior to the expanded role. Forty-four percent of the NPs had three to five years in nursing before they began the NP role. With limited educational preparation and limited nursing experience, one might expect to find the role ambivalence that this study indicates existing both in how NPs are functioning and desire to function.

NPs varied considerably on which tasks they desired or believed capable of performing. NPs must become familiar with their rules and regulations of their specialty relating to scope of practice. Before accepting any position as a NP, the prospective job description should be read and analyzed to determine if the functions described are within legal boundaries. Educational programs need to teach what practices are within the scope of the specialty area. The researcher supports Bullough (1975) in that much of the present role ambiguity can be contributed to the lack of uniformity in length, content, structure, and clinical practice of the NP educational programs.

There exists much variation about the role and expectations. Physicians and NPs themselves are confused and unsure about what functions are appropriate for this role. If there is so much variation within the NPs themselves concerning their role expectations, physician and public misunderstanding can certainly be expected. The researcher agrees with Banahan and Sharpe (1979) that much of the physician opposition to NPs may be due

to lack of knowledge about the role. There has to be more understanding within the nursing profession as well as between the nursing and medical professions if consistency of health care is to be maintained. The researcher suggests that NPs make a concerted effort to delineate their role and communicate this to the public and physicians.

There was only one NP who indicated practice without protocols, and the researcher believes that the law should require protocols for management of health care problems by therapeutic regimes with a medical component. NPs may unknowingly be exceeding the scope of the expanded role because protocols are too general or virtually non-existent. Without well-defined protocols that are submitted to a governing body for its approval, some NPs will continue to exceed legal boundaries in the tasks they are performing. This produces role stress within NPs. Unless the NP role is well defined and the tasks performed well delineated, the continuation of the role is unstable.

The lack of legal definition and sanction of NPs provided on the state level has been identified in previous research (Touslee, 1981). NPs have an obligation to become active on the state level to develop adequate rules and regulations to govern practice and to develop legislation to ensure continuation of the role. If the state fails to define the functions of the NP, the legality of the NP's practice is in question as well as the public's safety. The NP is personally responsible and accountable for all of his/her acts. The researcher questions how NPs can be accountable for providing

health care if they are unsure what component of health care they can legally provide.

The data demonstrate that NPs desired collaborative practice with a physician instead of independent practice. The study found that 75.6 percent of the NPs desired to be within five miles of the collaborative physician and 46.7 percent of these desired to be in the same office with the physician. This implies to the researcher that NPs desire to be a part of the health care team instead of in competition with physicians. To accomplish this the researcher suggests that NPs must be actively involved in workshops and committees that jointly meet with physicians. Nurses need to make their desires known to physicians so that the physicians realize that the goal of the expanded role is to achieve better health care through collaboration not independence. NPs and physicians should jointly define the role of the expanded nurse. Such collaborative action would help the physicians to better understand the role which would hopefully result in decreased stress between the two groups of health care providers. This process is currently being employed in Mississippi and shows promise of being successful.

NPs may desire to practice less than five miles away from their back-up physician but may presently be functioning in rural areas at a distance from the back-up physician due to the shortage of medical care in these areas. The reality of health care often prevents NPs from practicing under optimum conditions. If NPs are to continue to provide adequate health care

to these rural areas, physicians must be willing to collaborate properly with nurses in the rural areas. Wright's (1975) and Fottler's (1979) studies showed that about one third of physicians are willing to take on the role of collaboration. If health care is going to reach the rural areas, physicians are going to have to relocate to these areas or agree to work in collaboration with NPs to provide the needed care. This is especially true of the NPs employed by the State Board of Health. Funds are limited within this agency to pay back-up physicians in each site where the practitioner has a clinic, and physicians are often unwilling to provide these services without remuneration.

Ninety-three percent of the NPs anticipated continuation of the expanded role. Eighty percent of the nurses were willing to provide time and 27 percent were willing to provide money to ensure continuation of the role. This indicates that there are resources available that can be used in campaigning for legislation or education to help preserve the expanded role. This willingness to provide time and/or money should be capitalized upon by proponents of the NP role in the struggle for definition and maybe existence. If NPs themselves have a part, then they are more likely to become actively involved.

Recommendations

In response to the expanded nursing role, a committee is presently working at the state level to redefine the scope of practice and requirements for practice. After the role is well delineated, the researcher recommends a

campaign to educate NPs, physicians, and clients regarding the boundaries of the role.

The questionnaire needs refinement so that this study can be replicated upon completion of the educational campaign suggested above. Since the states differ so widely in their requirements for practice, it would be advantageous to replicate this study with NPs in other states.

The researcher also recommends a longitudinal study over a period of ten years to see if NP perceptions change as their experience changes. Another study could be done to see if experience, educational level, or other demographic variables correlate with performance in and knowledge of the role. If education, nursing experience, or other demographic variables do show a high correlation, then the need for including these in minimum requirements for practice in the expanded role may be considered.

Educational programs need more consistency in educating nurses for this role. The scope of practice of each specialty taught should become a mandatory part of every curriculum. In fact, the researcher suggests that the focus of another research study could be to determine the content of nurse practice curriculums regarding scope of practice.

This study should also be replicated using a larger sample. Continued testing and refinement of the tool would enhance data collected in other studies.

APPENDICES

Questionnaire

Please answer the following questions by circling the appropriate response(s) or by filling in the space.

Demographic Variables

1. Age to nearest birthday _____

2. Sex _____

3. Specialty area of nurse practitioner preparation _____

4. Specialty area of present nurse practitioner practice _____

5. Basic nursing preparation:

   associate degree — baccalaureate degree
   diploma — masters

6. Nurse practitioner preparation gained in which of the following programs:

   certificate — baccalaureate — masters

7. Length of nursing experience prior to the nurse practitioner role:

   less than one year — less than ten years
   less than three years — ten or more years
   less than five years

8. Length of time in nurse practitioner role:

   less than six months
   six months to one and one-half years
   one and one-half years to three years
   more than three years

9. Principal site(s) of nurse practitioner practice:

   community health center; physician's office; nurse clinic; city, county, state health department; hospital outpatient clinic; rehabilitation facility; extended care facility; industry; school; visiting nurse association; other _____

10. Population setting of nurse practitioner practice:

rural (2,500 or less)
town (2,501 to 5,000)
small city (5,001 to 25,000)
medium-sized city (25,000 to 100,000)
large city (over 100,000)

11. Economic setting of nurse practitioner practice (Patients' average income level)

poverty income
low-middle income
middle income
upper-middle income
affluent

12. Distance from physician back-up:

in same office
less than five miles away
less than twenty-five miles away
less than fifty miles away
fifty or more miles away

13. Distance you desire from physician back-up:

in same office
less than five miles away
less than twenty-five miles away
less than fifty miles away
fifty or more miles away

14. Method(s) of contact with back-up physician:

visits to clinic
telephone hook-up
other (please explain) _____

15. Frequency of back-up physician visits at your practice site:

none
several times a day
once a day
2-3 times a week
once a week
2-3 times a month
once a month
less than once a month

If the above frequency is different from your wishes, how often do you desire back-up physican visits at your practice site? _____

16. Frequency of contact with back-up physician by means other than visits:

none	once a week
several times a day	2-3 times a month
once a day	once a month
2-3 times a week	less than once a month

If the above frequency is different from your wishes, how often do you desire contact with your back-up physician by means other than visits? _____

17. Do you believe that you have adequate back-up from your physician?

Yes No

18. Which do you prefer? collaborative practice with a physician
independent practice

19. Protocols should be:

very restrictive	very general
detailed but allowing for nursing judgment	nonexistant

20. Your present protocols are:

adequate	too general
too restrictive	nonexistant

21. Are you performing tasks that you believe are or should be beyond the scope of your nurse practitioner role? If yes, please explain.

Yes _____
No

22. Do you believe that all of the functions that are expected of you and the tasks that you perform are covered by the rules and regulations of your particular specialty?

Yes No

23. Do you believe that the existing rules and regulations governing your specific practice are specific enough?

Yes No

24. Which would you contribute to the effort for preservation of the nurse practitioner role?

money time neither

25. Do you anticipate continuation of the nurse practitioner role?

Yes No

26. Are you satisfied with your role as a nurse practitioner?

Yes No

In this study it is important to know not only what tasks the nurse practitioner is presently performing but also what tasks the nurse practitioner desires to perform. Both the desired and actual performed tasks will be considered in this questionnaire so that it can be determined if nurse practitioners are performing the tasks that they desire.

DIRECTIONS:

If the task is one that is not applicable to your specific specialty area, check the "not applicable" column. If you believe the task is beyond the role of the expanded nurse, then check the "not in the role" column and go on to the next task. If the task is part of your role, then under the "actual performance" column, check the manner in which you are currently performing it. If the task is part of your role, but you are not performing it check the "not performing" column. Please, likewise, indicate in the "desire to perform" columns the manner in which you desire to perform each task.

If you did not check the "not applicable" column or the "not in the role" column, you should have two checks present indicating how you are presently performing the task and how you desire to perform it. See example below for how your form might look.

			Actual Performance			Desire to Perform		
Task	N/A	Not in Role	WSP	Collab.	Not Perf.	WSP	Collab.	Not to Perform
Dil. Pupils	X	X						
Rem. Sutures			X				X	

Without Specific Protocol (WSP)--performed without specific protocol/consultation.
Collaboratively (Collab)--Performed either by definitive protocol, telephone/personal consultation.
N/A--Not Applicable. Not in role--Beyond the scope of the expanded role.

Task	N/A	Not in Role	Actual Performance			Desire to Perform		
			WSP	Collab.	Not Performing	WSP	Collab.	Not to Perform
1. Take a routine medical history								
2. Remove sutures								
3. Counsel patients on family planning								
4. Prescribe diabetic diets for new diabetics								
5. Manage patients with chronic disorders								
6. Provide routine prenatal care								
7. Aspirate joint fluid from knees								
8. Perform complete physical exam								
9. Tape ankle, wrist or knee for immobilization								
10. Palpate uterus for fetal position								
11. Regulate medication dosage for diabetics								
12. Adjust medication for patient with benign essential hypertension								
13. Perform well-baby check-ups								
14. Interpret EKG								
15. Diagnose and treat acute otitis media								

Task	N/A	Not in Role	Actual Performance			Desire to Perform		
			WSP	Collab.	Not Performing	WSP	Collab.	Not to Perform
16. Incise and drain abscess								
17. Provide health education								
18. Begin initial medication treatment for hypertensive								
19. Dilate pupils								
20. Monitor health status of chronically ill or post-operative patients through home and hospital visits								
21. Suture using local anesthetic								
22. Prescribe non-controlled medication								
23. Set fractures								
24. Manage psychotic patients								
25. Order steroids for diseases of the eye								

Appendix B

Letter of Explanation

108 Gardenia
Columbus, Mississippi 39701
March 24, 1981

Dear _____:

My name is Cindy Gaskins. I am a graduate nursing student in the Family Nurse Clinician program at the Mississippi University for Women in Columbus, Mississippi. As a part of the requirements for graduation, I am writing a thesis on nurse practitioners' perceptions of the expanded nursing role. It would be most helpful if you would agree to participate in my study by completing the enclosed questionnaire and sending it back to me in the enclosed self-addressed envelope. All participants' names will be anonymous.

I realize the demands on your time are great, but I believe that the results of this study will benefit all nurse practitioners by helping to clarify the expanded role and reducing role stress. Your participation will be greatly appreciated. Please return the survey within two weeks if possible. Thank you.

Gratefully,

Cindy Gaskins, R.N.

Appendix C

Subject Consent Form

Descriptive Study: An Introspection of the Role of the Nurse Practitioner

My name is Cindy H. Gaskins. I am conducting a research study in order to determine nurse practitioners' perceptions of their expanded role. I would like each nurse practitioner to complete a questionnaire. This survey will help to better understand the nurse practitioner role, thus reducing role stress and improving the quality of health care.

I understand the explanation given to me. Further, I understand that I have the right to withdraw from the study at any time if I so desire, and that my identity will be treated as confidential information.

_____ _____

Date Subject's Signature

I explained this study to the subject on the date given and expressed to her that the information would be used for educational purposes, and her identity would be treated as confidential information.

_____ _____

Date Investigator

References

Andrews, L. H., & Fenley, M. Assistants to primary care physicians in California. Western Journal of Medicine, 1975, 122, 80-86.

Aufhauser, T. R., & Lesh, D. Nursing: Parents need TLC, too. Hospitals, 1973, 47, 88.

Banahan, B. F., & Sharpe, T. R. Attitudes of the Mississippi physicians toward nurse practitioners. Journal of the Mississippi State Medical Association, 1979, 20, 197-201.

Beason, C. Nurse practitioners: the flak from doctors is getting heavier. Registered Nurse, 1978, 41, 27-37.

Bible, B. L., and McComas, J. D. Role consensus and teacher effectiveness. Social Forces, 1963, 42, 225.

Blackwood, S. A. At this hospital 'the captain of the ship' is dead. Registered Nurse, March 1979, pp. 77-94.

Bleich, J. Level of health care remains inadequate. Clarion Ledger, May 1979.

Borgotta, E. Role playing specification, personality and performance. Sociometry, 1961, 24, 218.

Bullough, B. The law and the expanding role. New York: Appleton-Century-Crofts, 1975.

Chenoy, N. C., Spitzer, W. O., & Anderson, G. D. Nurse practitioners in primary care: Part 2. Prior attitudes of a rural population. Canadian Medical Association Journal, 1973, 108, 998-1003.

Conway, M. E. Theoretical approaches to the study of roles. In M. E. Hardy & M. E. Conway (Eds.), Role theory: perspectives for health professionals. New York: Appleton-Century-Crofts, 1978.

Coulehan, J. L., & Sheady, S. The role, training, and one-year's experience of a medical nurse practitioner. Health Services Reports, 1973, 88, 827-833.

Davis, F. & Olesen, V. Initiation into a women's profession: identity problems in the status transition coed to nursing students. Sociometry, 1963, 26, 89.

DeCastro, F. J., & Rolfe, V. T. On the job training of the pediatric nurse practitioner: an evaluation. Missouri Medicine, 1973, 70, 185-187.

Durbin, E., & Zuckerman, S. Legislation affects nursing practice. Nursing Administration Quarterly, 1978, 2, 39-50.

Ford, L. C. A nurse for all settings: the nurse practitioner. Nursing Outlook, August 1979, pp. 516-521.

Fottler, M. D. Physician attitudes toward physician extenders - a comparison of nurse practitioners and physician assistants. Medical Care, 1979, 17, 536-549.

General population characteristics: Mississippi. 1970 Census of Population, U. S. Bureau of the Census.

Getzels, J. W., & Guba, E. G. Role, role conflict and effectiveness: an empirical study. American Sociological Review, 1954, 19, 164.

Gilchrist, J. Collaboration, not competition. Canadian Nurse, 1978, 74,4.

Goye, R. D., & Hansen, M. F. The "doctor's assistant:" a survey of physicians' expectations. Journal of the American Medical Association, 1969, 209, 529.

Greene, C., & Organ, D. An evaluation of causal models linking the received role and job satisfaction. Administrative Science Quarterly, 1973, 18, 95.

Hall, V. C. Statuatory regulations of the scope of nursing practice. Chicago, Illinois: The National Joint Practice Commission, 1975.

Hardy, M. E. Role stress and role strain. In M. E. Hardy & M. E. Conway (Eds.), Role theory: perspectives for health professionals. New York: Appleton-Century-Crofts, 1978.

Henriques, C. C., Virgadamo, V. G., & Kahane, M. D. Performance of adult health appriasal examinations utilizing nurse practitioners--physician teams and paramedical personnel. American Journal of Public Health, 1974, 64, 47-53.

Hinshaw, A. S. Role attitudes: a measurement problem. In M. E. Hardy & M. E. Conway (Eds.), Role theory: perspectives for health professionals. New York: Appleton-Century-Crofts, 1978.

Karp, S. S., Metzler, J., & Hansen, C. M. The pediatric nurse practitioner in the private office. Journal of the Medical Society of New Jersey, 1973, 70, 773-776.

Kinlein, M. L. Independent nursing practice with clients. Philadelphia: J. B. Lippincott Company, 1977.

Kubala, S., & Clever, L. H. Acceptance of the nurse practitioner. American Journal of Nursing, 1974, 74, 451-452.

Lawrence, R. S., DeFriese, G. H., Putnam, S. M., Pickard, C. G., Cyr, A. B., & Whiteside, S. W. Physician receptivity to nurse practitioners: a study of the correlates of the delegation of clinical responsibility. Medical Care, 1977, 15, 298-310.

Levine, E. What do we know about nurse practitioners? American Journal of Nursing, 1977, 77, 1799-1803.

Levine, J. I., Oir, S. T., Sheatsley, D. W., Lohr, J. A., & Brodie, B. M. The nurse practitioner: role, physician utilization, patient acceptance. Nursing Research, 1978, 27 (4), 245-254.

Lewis, C. E., & Rosnik, B. A. Nurse clinics and progressive ambulatory patient care. New England Journal of Medicine, 1967, 277, 1236-1241.

Little, M. Physicians' attitudes toward employment of nurse practitioners, Nurse Practitioner, 1978, 3 (4), 27-30. (a)

Little, M. Physicians' attitudes toward employment of nurse practitioners, Nurse Practitioner, 1978, 3 (6), 26-29. (b)

MacKay, R. C., Alexander, D. S., & Kingsbury, L. J. Parents' attitudes towards the nurse as physician associate in a pediatric practice. Canadian Journal of Public Health, 1973, 64, 121-132.

Martin, H., & Katz, F. The professional school as a moulder of motivation. Journal of Health and Social Behavior, 1961, 2, 106.

Mentink, J. L., Trolinger, J., & O'Hara-Devereaux, M. Nurse practitioners in primary care. Family and Community Health, 1980, 3 (2), 21-25.

Miike, L. The future of new health practitioners. Family Community Health, 1979, 2, 65-78.

Misunderstandings cut health clinic use. Northeast Mississippi Daily Journal, October 1980.

National Joint Practice Commission. Joint practice: a new dimension in nurse-physician collaboration. American Journal of Nursing, 1977, 77 (9), 1466-1468.

O'Dell, M. L. Physicians' perceptions of an extended role for the nurse. Nursing Research, 1974, 23, 348-351.

Physician extenders 'essential' to rural practice. Family Practice News, November 1980, pp. 3; 36-37.

Polit, D. F., & Hungler, B. P. Nursing research: principles and methods. New York: J. B. Lippincott Company, 1978.

Prediction of family practice surplus meets with skepticism. Family Practice News, November 1980, p. 1.

Prescott, P. A., & Driscoll, L. Evaluating nurse practitioner performance. The Nurse Practitioner. 1980, 5 (4), 28-32.

Schiff, D. W., Fraser, C. H., & Walters, H. L. The pediatric nurse practitioner in the office of pediatricians in private practice. Pediatrics, 1969, 44, 62-68.

Smelser, W. Dominance as a factor in achievement and perception in cooperative problem solving interactions. Journal of Abnormal and Social Psychology, 1961, 62, 535.

Smith, E. E. The effects of clear and unclear role expectations on group productivity and defensiveness. Journal of Abnormal and Social Psychology, 1957, 55, 213.

Touslee, C. L. Current legal status of the expanded role by state. Unpublished masters thesis, Mississippi University for Women, 1981.

Trandel, D. M., & Korenchek, K. M. Advanced nursing practice. Nursing Outlook, 1978, 26, 713-719.

Trenting, E. G. Nurse practitioners: preparations and role. Community Health Today and Tomorrow. New York: National League for Nursing Publication No. 52-1768, 1979.

Ward, M. J. Family nurse practitioners; perceived competencies and recommendations. Nursing Research, 1979, 28, 343-347.

Weinstein, P., & Demers, J. L. Rural nurse practitioner clinic: the public's response. American Journal of Nursing, 1974, 74, 2022-2026.

Weisgerber, E. The nurse practitioner: medicolegal considerations. Legal Medical Annuity, 1977, 283-295.

Wright, E. Family nurse clinicians: physicians' perspective. Nursing Outlook, 1975, 23, 771-773.

Yankauer, A., Tripp, S., Andrews, P., & Connelly, J. P. The outcomes and service impact of a pediatric nurse practitioner training program--nurse practitioner training outcomes. American Journal of Public Health, 1972, 62, 347-353.